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A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes Among Second-Year Medical Students

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DEVELOPMENTS

A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes Among Second-Year Medical Students

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***Background*: Lesbian, gay, bisexual, and transgender (LGBT) persons represent an underserved population susceptible to health care disparities. *Description*: In February 2004, we implemented an LGBT health curriculum for students at the University of California at San Francisco. Confidential matched questionnaires elicited students' knowledge, attitudes, and beliefs about LGBT health issues before and after the intervention. *Evaluation*: The surveyed population (52% response rate) was demographically similar to the entire class. There was statistically significant change in the responses to 4 of 16 questionnaire items ($p \leq .001$; largest absolute change was 0.57 on a 5-point scale). Students demonstrated increased knowledge about access to health care and LGBT relationships, increased willingness to treat patients with gender identity issues, and enhanced awareness that sexual identity and practices are clinically relevant. *Conclusions*: Our simple curricular intervention led to significant short-term changes in a small number of survey items assessing students' knowledge and beliefs about LGBT persons.**

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The opinions contained herein are those of the authors and do not necessarily represent the views of the U.S. Department of Veterans Affairs or the University of California. An abstract of this study was presented at a poster session at the Association of Professors of Gynecology and Obstetrics Annual Meeting, Salt Lake City, UT, April 2005. We thank Stacy Carter for her assistance with data management at the Lesbian Health & Research Center, UCSF, and Patricia O'Sullivan, Ed.D., for comments on an earlier version of this article.

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There has been increasing focus within medical education on developing interpersonal skills and "cultural competence" of medical students.[1,2] This trend is part of a more widespread recognition of the deep-seated biases that adversely affect not only individual patient–physician relationships but also population-wide access to and quality of care in minority and marginalized communities. In creating medical school curricula to address these concerns, educators have largely concentrated attention on traditionally marginalized communities, such as immigrant and/or ethnic communities.

More recently, recognition of the impact of bias on other groups, especially on sexual minorities, has widened the focus of this education.[3]

In 1994, the American Medical Association issued a policy statement stating a commitment "to taking a leadership role in educating physicians on the current state of research and knowledge of homosexuality . . . which should start in medical school [and] must be a part of continuing medical education."[4] Despite this strong statement, inclusion of lesbian, gay, bisexual, and transgender (LGBT) health issues in medical school classrooms nationwide has been slow and inconsistent. A 1991 study surveying U.S. medical schools found that an average of 3.5 hr over the entire 4 years was devoted to LGBT health topics.[5] Although no similar study has been done in the intervening years, a 1998 survey of family practice departments revealed that more than 50% devoted no time at all to educating undergraduate medical students about LGBT health issues. Of those departments that did include the topic, the reported average time allotted was 2.5 hr.[6]

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Meanwhile, it has become clear that LGBT persons represent a significantly understudied and underserved patient population. Discrimination against gay men in the health care setting has been well recognized since the early days of the HIV epidemic and continues to be prevalent.[7] The 1999 Institute of Medicine report on lesbian health concluded that lesbians as a group faced substantial financial, structural, and personal barriers in equal access to health care.[8] Finally, transgender persons experience dramatic health disparities.[9]

Here, we describe the effects of a curriculum designed to illuminate LGBT health care disparities and to facilitate dialogue between medical students and members of the LGBT communities.

METHODS

At the University of California at San Francisco (UCSF), medical students raised concerns about the inadequacy of their instruction on LGBT health issues. In response, the directors of the 2nd-year interdisciplinary Life Cycle Course designated a 2-hr time block for LGBT health. Student participation in the Life Cycle course is a central part of the UCSF medical school curriculum. Attendance is not required at entire-class sessions but is mandatory for small-group experiences.

Curriculum for this block was developed cooperatively by the authors, with input from educators, physicians, and members of the LGBT communities. The curriculum goals and objectives were (a) to increase awareness of students' existing assumptions about LGBT people, (b) to highlight disparities of health care to which LGBT patients are vulnerable, and (c) to underscore the important role that physicians can play in dispelling these disparities to optimize LGBT health care.

To achieve these objectives, in February 2004 we designed a three-part intervention composed of a syllabus, a 1-hr patient panel, and a 1-hr small-group session focusing on case studies. The syllabus, distributed prior to class, included an introduction emphasizing basic definitions and the health hazards of homophobia; descriptions of specific primary care issues for lesbians and for gay men; and an introduction to transgender terms, health issues, and social context. Care was taken to highlight the tremendous variation among LGBT people and the need for individualized evaluation and care. A sensitive, informed and nonjudgmental clinical approach to each LGBT patient was emphasized throughout.

Because prior studies indicate that direct contact with patients helps medical students form more positive impressions of marginalized patient populations,[10–12] we designed a whole-class patient panel session to highlight difficulties in accessing care and establishing trust with providers. It consisted of three voluntary participants: an older gay man, a middle-age lesbian, and a young transgender man. A short presentation by each panelist was followed by an interactive question-and-answer session.

Immediately after the panel, students convened into 10 small groups of 14 students each. The groups had previously been assembled for the course, so students were already well acquainted with others in their group. Group leaders were 10 LGBT faculty physicians and residents, who shared their personal and professional "coming out" process with students. The groups then discussed three cases, each designed to highlight several critical LGBT health issues. Case 1 addressed the interactions of a health care practitioner with a lesbian who discovered a breast mass when she was weaning her daughter. Case 2 considered the differential diagnosis and workup of a gay business man with gastrointestinal symptoms. Case 3 involved the evaluation and counseling of a teen with a chest rash from binding her breasts to pass as male.

We developed a survey consisting of 16 statements, answered on a scale of 1 (*strongly agree*) to 5 (*strongly disagree*). Because no appropriate validated survey tool existed, this questionnaire was designed by the authors to broadly characterize student knowledge, attitudes and experience regarding a range of LGBT health issues.[13,14] Content was based on the Index of Attitudes toward Homosexuals[15] and the conceptual framework of Blumenfeld describing personal/interpersonal, institutional, and cultural aspects of homophobia.[16] We similarly formatted questions geared toward specific knowledge and experience relevant to medical students. It was also expanded to address student attitudes and experiences regarding persons with gender variations. The survey was initially piloted in a 4th-year medical student sexual health elective in 2003 and had content validity. Because the survey also included knowledge items, it was not appropriate to test for reliability because multiple concepts were being measured.

Approval from the UCSF Committee on Human Research was obtained to survey students before and after the curriculum presentation. Students' participation was entirely voluntary; each received an informed consent form with information about the intentions and structure of the study. Each participating student received a state lottery ticket as compensation.

About 2 weeks prior to the panel and small group, students received a questionnaire after the completion of an unrelated but required exam in their Life Cycle course. Students completed the questionnaire anonymously but were asked to provide the last three digits of their cell phone number, which allowed them to be paired with follow-up surveys. Entrance surveys also elicited demographic information about each student, including age, sex, and sexual orientation (heterosexual, homosexual, or bisexual). Students completed an identical questionnaire at the conclusion of the 2-hr teaching module in the small-group setting. Exit questionnaires, again coded with the three-digit number, also included information about attendance, syllabus reading, and students' other sources of knowledge in the subject area.

Only surveys for which both pre- and postclass information was obtained were analyzed. Student responses from before and after the educational module were compared using paired T tests. Subgroups of students were created on the basis of

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TABLE 1
Demographic information

Demographic Characteristics	Study Group	Total Students in the Class
Students (n)	75	143
Age (Myears)	25.4	25.7
Gender*		
Male	25 (33.3%)	59 (41%)
Female	50 (66.7%)	84 (59%)
Ethnicity		
African American/Black (non-Latino)	2 (2.7%)	5 (3.5%)
American Indian or Alaskan Native	1 (1.3%)	2 (1.4%)
Asian or Asian American	26 (34.7%)	47 (32.9%)
Latino or Hispanic	9 (12%)	14 (9.7%)
Multiethnic or Mixed	2 (2.7%)	11 (7.7%)
White	33 (44%)	62 (43.4%)
Other	2 (2.7%)	2 (1.4%)
Sexual Orientation		
Heterosexual	71 (94%)	NA
Bisexual	3 (4%)	
Lesbian/Gay	1 (1.3%)	
Transgender/Other	0 (0%)	

Note: Unless indicated, values are N(%). NA = Data not available.
*$p < .05$.

certain responses, and changes in responses were similarly analyzed. Statistical analyses were completed using SPSS software (Chicago, IL).

All students were also asked to evaluate the LGBT health module in the larger context of the course. Small group leaders were individually evaluated using the Web-based E-value system. Following the completion of the Life Cycle curriculum, students also completed course evaluations that included the LGBT health module.

RESULTS

Demographics

Overall, 75 students (52% of those enrolled in the course) completed the pre- and postintervention questionnaires. Not all respondents were exposed to the entirety of the curriculum: 60 of 75 (80%) reported reading the syllabus prior to attending class, and 64 of 75 (85%) reported attending the patient panel. All of the study participants attended the small-group session. Demographics of the study group were comparable to those of the entire 2nd-year medical student class in ethnic background and age (Table 1), but significantly fewer men did not complete the survey ($p < .05$). Information on the sexual orientation of study participants was obtained; however, no comparison data existed for the student body as a whole.

Evaluation of the Curriculum

More than 90% of survey respondents agreed or strongly agreed that the syllabus, patient panel, and small-group cases helped educate them about LGBT issues (Table 2). Postintervention surveys elicited comments for the curriculum. All 75 respondents offered some comment on the postclass survey, and these were overwhelmingly positive. Students found that hearing personal stories from patients and physicians was helpful

TABLE 2
Quantitative evaluation of the curriculum

Survey statements	% of Students Selecting 1 (*Strongly Agree*) or 2 (*Agree*)
"The **syllabus** helped to educate me about LGBT issues."	91%
"The **patient panel** helped to educate me about LGBT issues."	92%
"The **cases/small groups** helped to educate me about LGBT issues."	96%

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and that the overall module was useful in identifying unconscious prejudices. Constructive comments mainly focused on the lack of time for the module and desire for skill exercises such as role-play.

At the completion of the Life Cycle course, all UCSF students evaluated the relative usefulness of the various modules and the quality of the small group leaders. Students rated the usefulness of the LGBT small groups at 3.77, from 1 (*poor*) to 5 (*excellent*); the overall course rating for the entire Life Cycle course was 3.93. Evaluations for the LGBT small-group leaders, in which students assessed the group leaders' preparedness, ability to facilitate discussion, and overall effectiveness, were at or above average for the course.

Changes in Students' Knowledge and Attitudes

Of the 16 survey statements to which students were asked to respond, 4 (25%) demonstrated significant change in average response before and after the learning intervention (Table 3). Two survey items demonstrated an increase in knowledge that LGBT communities experience differential access to health care

TABLE 3
Survey Responses

	Pre-Class ($M \pm SD$)	Post-Class ($M \pm SD$)	Effect Size (d)	p
Knowledge				
2. Access to health care is the same for LGBT persons as for other members of the population.	**3.55 ± 1.01**	**4.12 ± 0.82**	**0.59**	**< .001**
4. Lesbian patients do not need Pap smears as frequently as heterosexual women.	4.36 ± 0.71	4.39 ± 0.77	0.03	.80
7. Most LGBT young people do their first "coming out" to a nonparent adult (e.g., a teacher or doctor)	3.15 ± 0.4	2.39 ± 0.9	0.49	.12
8. Gender reassignment surgery is easily available and is covered by most insurance policies.	4.51 ± 3.54	4.08 ± 0.88	0.29	.29
10. LGBT people are less likely than heterosexual people to be in long-term monogamous relationships.	**3.96 ± 0.95**	**4.31 ± 0.75**	**0.38**	**.001**
Attitudes				
1. LGBT populations have unique health risks and health needs.	1.51 ± 0.58	1.67 ± 0.9	0.19	.15
6. I would feel comfortable treating patients I know are LGBT.	1.79 ± 1.00	1.67 ± 0.92	0.12	.44
9. I believe that homosexuality is immoral.	4.41 ±1.14	4.44 ± 1.08	0.03	.77
12. As a physician, I feel it is important for me to know about my patients' sexual orientation, sexual practices and gender identity.	**1.52 ± 0.66**	**1.21 ± 0.44**	**0.42**	**< .001**
13. I would prefer not to treat patients with minority sexual orientation.	4.56 ± 0.55	4.55 ± 0.55	0.01	.83
16. I would prefer not to treat patients with gender identity issues.	**4.25 ± 0.73**	**4.52 ± 0.62**	**0.33**	**.001**
Experiences				
3. I regularly encounter LGBT individuals in my daily life.	1.91 ± 0.87	1.89 ± 0.83	0.02	.90
5. Knowing someone is LGBT significantly alters the way I perceive that person.	3.63 ± 1.07	3.39 ± 1.01	0.23	.07
11. I feel comfortable around people whose gender presentation is ambiguous.	2.71 ±0.99	2.60 ± 0.9	0.11	.27
14. When I first meet a patient or colleague, I assume they are heterosexual.	3.08 ± 1.1	3.21 ± 0.99	0.13	.27
15. My experiences with LGBT individuals have positively altered my beliefs about sexuality and gender identity.	1.95 ± .084	1.79 ± 0.92	0.17	.16

Note: Students were asked to complete a questionnaire with the following items 2 weeks before and directly after the curricular module. Items are grouped by category but enumerated as they originally appeared on the survey. Items with statistically significant changes in the postcurriculum questionnaire are depicted in bold type: 1 (*strongly agree*), 2 (*agree*), 3 (*uncertain*), 4 (*disagree*), 5 (*strongly disagree*).

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and that LGBT couples are as likely to have long-term monogamous relationships as heterosexual couples. Two items showed a significant change in student attitudes: increased willingness to treat people with gender identity issues and enhanced awareness that sexual orientation, identity, and practices are relevant to clinical practice. The largest absolute change for any survey item ("Access to health care is the same for LGBT persons as for other members of the population") was 0.57 on a 5-point scale. The p values for the changes for all four statements were less than .001.

CONCLUSIONS

Our study demonstrates the efficacy of a short, focused intervention in changing important aspects of the knowledge and attitudes of medical students toward LGBT persons. Our curriculum is brief, comprehensive, and flexible, and it represents the only documented instance in the literature of using small groups to effectively teach preclerkship medical students about LGBT health care. In addition, curricular innovators can easily adapt this material to a variety of settings while preserving its essential educational content. In 2 hr and with the use of inexpensive in-house resources, we were able to show a positive impact on students' knowledge and attitudes.

The creation of effective and broadly applicable curricula that enhance the cultural competency in medical students is a major challenge for medical educators. Although the importance of enhancing medical curricula with teaching about LGBT issues was strenuously noted nearly 10 years ago,[4,17] only two curricular innovations have been published.[18,19] Our study confirms that curricular introduction can enhance learners' preparation in managing LGBT health issues. In addition, one of our most important outcomes was the students' increased willingness to provide care for transgender patients in the future.

We believe that the efficacy of our curriculum rests in large part on its emphasis on the social and cultural aspects of LGBT health. In discussing the increased health risks encountered by LGBT individuals, it is essential for students to understand that a common causative factor in these health risks is not necessarily in merely *being lesbian, gay, bisexual, or transgender*; rather, it is *living as a LGBT person in a homophobic society*.[3] Like all forms of social prejudice, homophobia has significant negative impact on the individuals and communities it targets. The significant changes in student perceptions about differential LGBT access to health care show that students learned about the tangible effects of homophobia. Students completing this program were also significantly more likely to believe that knowing about their patients' sexual orientation and gender identity was an important part of providing care than when they started. As visibility has been one of the major hurdles toward LGBT inclusion in health care settings, we are hopeful that increased awareness will lead toward greater inclusiveness.

Survey questions that did not demonstrate significant change pre- versus postcurriculum are also revealing (Table 3). As expected, questions examining students' experiences with LGBT persons did not change dramatically in the course of a 2-hr session but may give insight into the background of these medical students. For example, the majority of students agreed with the statement, "I regularly encounter LGBT individuals in my daily life." Furthermore, students appeared to be fairly well informed before the module. For example, the majority of students disagreed with the statement, "Lesbian patients do not need Pap smears as frequently as heterosexual women." The absence of change in statements such as "I believe that homosexuality is immoral" and "I would feel comfortable treating patients I know are LGBT" may indicate that such attitudes are firmly entrenched by this stage of medical training. By contrast, the significant change in student attitudes toward those with gender variations demonstrates that student discomfort with these patients may primarily be related to lack of exposure.

There are several important limitations to this study. First, the overall efficacy of the curriculum is moderate, given the low survey response rate (52%), statistically significant change in only 4 of 16 survey items, and largest absolute change of 0.57 on a 5-point scale. Therefore, the respondents may represent a group of students for whom this curriculum may have been most effective. The overall rating of the module in the context of the course as a whole was not significantly different from other course modules, suggesting that selection bias may be limited. Second, we measured outcomes immediately after the curricular module but did not assess long-term incorporation of these concepts and attitudes into students' thinking and practice. Finally, certain aspects of our intervention may affect its portability. Of importance, as noted, the inclusion of LGBT issues in the standard curriculum at UCSF came about through student initiative. The inclusion of LGBT faculty members and residents as small-group leaders may have contributed to the positive change in student attitudes. Although it is likely that most medical schools have one or more LGBT faculty members, the availability of such large numbers of faculty willing to dedicate time and to share personal stories may vary by location. An alternative would be to recruit small-group leaders from a broader range of roles including fellows, nurses and residents, and/or LGBT-sensitive heterosexual colleagues.

This study introduces one approach to the development of practical and effective education in LGBT health. Future directions for research include long-term follow-up to measure the ongoing efficacy of similar teaching interventions. Educational goals also include the integration of LGBT health issues and concerns into the broader patient-oriented medical curriculum. The creation of national resources for educators seeking to integrate LGBT health into medical curricula could greatly facilitate more widespread exposure to this important information.

This curriculum is posted on the Web site of the Lesbian Health & Research Center at UCSF: http://www. lesbianhealthinfo.org. Institutions are welcome and encouraged to copy and implement it.

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APPENDIX

Terms

Sexual orientation: a self-identified characteristic describing to which gender an individual is sexually attracted. If the attraction is to someone of opposite gender, the orientation is heterosexual; if to the same gender, the orientation is homosexual (gay); and if to both genders, it is bisexual. Rather than being dichotomous, human sexuality is a continuum between straight and gay with individuals having variable levels of sexual attraction to people of the same and opposite genders.

Sexual identity: a person's self-identification with one's sexual orientation.

Gender identity: a person's self-identification with maleness, femaleness, or a third gender. This self-identification is separate and distinct from one's sexual orientation or sexual identity.

Homophobia: an irrational fear of, aversion to, or discrimination against gay, lesbian, bisexual or transgender people.

Heterosexism: the cultural socialization of heterosexuals as a dominant group against homosexuals and transsexuals and the concomitant conditioning of gays, lesbians, bisexuals, and transsexuals against themselves.